STATEMENT OF CONSIDERATION RELATING TO
907 KAR 10:014

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 10:014 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 10:014:

Name and Title	Organization/Agency/Other Entity
Rebecca Randall, Director of Regulatory Affairs	WellCare
Sharon D. Perkins, Director Health Policy	Kentucky Hospital Association
Kristi Hall, President	Kentucky Academy of Physician Assistants

(3) The following individual from the promulgating agency responded to comments received regarding 907 KAR 10:014:

Name and Title	Organization/Agency/Other Entity
Leslie Hoffmann, Director	Department for Medicaid Services, Division of Community Alternatives
Ann Hollen, Program Manager	Department for Medicaid Services, Division of Community Alternatives
Jonathan MacDonald, Policy Analyst	Department for Medicaid Services, Commissioner's Office
Stuart Owen, Regulation Coordinator	Department for Medicaid Services, Commissioner's Office

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Prior Authorization

(a) Comment: Rebecca Randall, Director of Regulatory Affairs, WellCare, stated the following:

"The proposed regulation language states that "A behavioral health service established in Section 5 of this administrative regulation shall not be subject to prior authorization." While WellCare does not dispute requiring prior authorization for screening and crisis intervention, we strongly disagree that intensive outpatient services should not require

prior authorization. We respectfully request that this language be revised to reflect that prior authorization be required for intensive outpatient program services."

(b) Response: The Department for Medicaid Services (DMS) appreciates the different perspective but staff involved in developing the policies does not recommend prior authorization for the services. Managed care organizations are free to impose prior authorization requirements that differ from DMS's requirements established for services to the "fee-for-service" population; thus, WellCare may impose prior authorization on intensive outpatient services if it so wishes.

(2) Subject: Crisis services

(a) Comment: Rebecca Randall, Director of Regulatory Affairs, WellCare, stated the following:

"Proposed language also states that mobile crisis services shall ensure 24/7 access to a board-certified or board-eligible psychiatrist physician. WellCare suggests that this same verbiage and requirement be added into the crisis stabilization units."

(b) Response: Residential crisis stabilization unit (RCSU) services' requirements are addressed in a separate administrative regulation – 907 KAR 15:070, Coverage provisions and requirements regarding residential crisis stabilization unit services. 907 KAR 15:070 is not currently being amended.

(3) Subject: Billing Supervisor

(a) Comment: Sharon D. Perkins, Director of Health Policy, Kentucky Hospital Association, stated the following:

"In the Amended Administrative Regulations, 907 KAR 10:014 Section 1 (5) Billing Supervisor means an individual who is; the term billing supervisor is somewhat confusing. KHA is requesting that "billing supervisor" be changed to "compliance supervisor" since the intent of the billing supervisor is to ensure compliance of supervision as required by statue."

(b) Response: DMS does not disagree with the term "compliance supervisor" but thinks either term is acceptable and as the term "billing supervisor" is used in many other DMS administrative regulations, DMS prefers to keep the term "billing supervisor" in this administrative regulation.

(4) Subject: Overpayment

(a) Comment: Sharon D. Perkins, Director of Health Policy, Kentucky Hospital Association stated the following:

"The language used in 907 KAR 10:014 Outpatient hospital service coverage provisions

and requirements Section 10 (b)1 Failure to return a payment to the department or managed care organization in accordance with paragraph (a) of this section may be: 1. interpreted to be fraud or abuse: and… KHA strongly opposes this language and the language is not consistent with prompt pay law at KRS 304.17A-700-730, which the managed care organizations are to abide by. There are specified procedures to follow for allowing facilities dispute claims by the Medicaid MCO of an overpayment. Failure to return an alleged overpayment does not constitute fraud and this should be deleted from the regulation."

(b) Response: The provision in the administrative regulation is not referring to disputes with an MCO and the word "may" rather than "shall" indicates not every scenario is a fraud or abuse scenario.

(5) Subject: Payments in full

(a) Comment: Sharon D. Perkins, Director of Health Policy, Kentucky Hospital Association stated the following:

"Additionally, Section 10(3) (a) 1. The payment shall be considered payment in full. The payment cannot be considered payment in full if the payment is incorrect. There are many errors made by the MCOs, both in their application of incorrect edits and paying an incorrect rate, whereby initial payment is not accurate. Certainly, we understand that the patient would not be billed the remaining balance but this language is unclear to that effect. We suggest altering the language to be clear that a provider may not balance bill a patient, except for copayments, for a service covered by Medicaid or a managed care plan."

(b) Response: DMS is revising the language as follows in an "amended after comments" administrative regulation.

"(3)(a) When the department or a managed care organization makes payment for a covered service and the outpatient hospital accepts the payment:
1. The payment shall be considered payment in full;
2. A bill for the same service shall not be given to the recipient; and
3. Payment from the recipient for the same service shall not be accepted by the outpatient hospital.
(b)1. An outpatient hospital may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:
a. Recipient requests the service; and
b. Outpatient hospital makes the recipient aware in writing in advance of providing the service that the:
(i) Recipient is liable for the payment; and
(ii) Department is not covering the service.
2. If a recipient makes payment for a service in accordance with subparagraph 1 of this paragraph, the:
a. Outpatient hospital shall not bill the department for the service; and

b. Department shall not:
(i) Be liable for any part of the payment associated with the service; and
(ii) Make any payment to the outpatient hospital regarding the service.
(c) Except as established in paragraph (b) or except for a cost sharing obligation owed by a recipient, a provider shall not bill a recipient for any part of a service provided to the recipient."

(5) Subject: Physician Assistants

(a) Comment: Kristi Hall, President, Kentucky Academy of Physician Assistants, stated the following:

"In 907 KAR 10:014, regarding outpatient hospital services, while PAs are included under the definition of an 'approved behavioral health services provider' they are also then placed into the category 'behavioral health practitioner under supervision,' which is given a secondary status under the identified 'billing supervisors.' This distinction is again used in a subsequent rule (907 KAR 9:020) as justification for drastically different reimbursement rates (see below). In addition, this rule does not list PAs among those able to perform basic functions such as requesting prior authorization, ordering diagnostic tests, and determining emergency situations."

(b) Response: DMS does not oppose autonomy for physician assistants; however, the corresponding document approved by the Centers for Medicare and Medicaid Services (state plan) only authorizes federal funding for services rendered by physician assistants under supervision. Until federal approval and funding is secured for behavioral health services rendered by independently practicing physician assistants, DMS is not incorporating the change in an administrative regulation.

(6) Subject: Amendments for Consistency/Clarity

(a) and (b) Comment and Response: DMS received comments on a related administrative regulation (907 KAR 9:015, Coverage provisions and requirements regarding outpatient services provided by Level I or Level II psychiatric residential treatment facilities which resulted in various amendments for clarity. DMS is revising the language in this administrative regulation accordingly to ensure consistency among administrative regulations.

The changes include clarifying that a face-to-face encounter is not required for any component of service planning that doesn't require the presence of the recipient or recipient's representative; clarifying that if an individual is under eighteen (18) years of age or unable to direct the development of their service planning then a representative may do so; clarifying that an assessment, case management, individual outpatient therapy, group outpatient therapy, peer support services, and mobile crisis services will not be covered if provided during the same period of time as assertive community treatment; and miscellaneous wording changes for uniformity or clarity.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 10:014 and is amending the administrative regulation as follows:

Page 30
Section 5(2)(i)1.a.
Line 23
After “the”, insert “recipient”.
Delete “individual”.

Page 31
Section 5(2)(i)1.b.
Line 1
After “b.”, insert “Recipient’s”.

Page 31
Section 5(2)(j)1.b.(i)
Line 17
After “the”, insert “recipient”.
Delete “individual”.

Page 31
Section 5(2)(j)1.b.(ii)
Line 18
After “(ii)”, insert “Recipient’s”.

Page 33
Section 5(2)(k)3.a.(i)
Line 5
After “the”, insert “recipient”.
Delete “individual”.

Page 33
Section 5(2)(k)3.a.(ii)
Line 6
After “(ii)”, insert “Recipient’s”.

Page 34
Section 5(2)(m)2.a.

Line 4
After “the”, insert a colon, a return, and “(i)”.

After “recipient”, insert the following:
; or
(ii) Recipient’s representative if the recipient is under the age of eighteen (18) years or is unable to provide direction

Page 34
Section 5(2)(n)2.c.
Line 22
After “address”, insert “the recipient’s”.

Page 48
Section 6(2)
Line 12
After “same”, insert the following:
period of time in which the recipient receives assertive community treatment

Delete the following:
date of service for the recipient

Page 52
Section 8(3)(b)3.c.
Line 11
After “enrollee”, insert “the”.

Page 53
Section 9(3)(a)1.f.
Line 19
After “f.”, insert “If applicable, the”.

Page 55
Section 9(4)(a)2.b.
Line 15
After “b.”, insert “Behavioral health practitioner’s”.
Delete “Therapist’s”.

Page 60
Section 10(3)(b)3.b.
Line 1
After “Department”, insert “or managed care organization”.

Page 60
Section 10(4)(a)

Line 4

Before “(4)(a)”, insert the following;

(c) Except as established in paragraph (b) of this subsection or except for a cost sharing obligation

owed by a recipient, a provider shall not bill a recipient for any part of a service provided to the recipient.